

Case Number:	CM14-0091175		
Date Assigned:	07/25/2014	Date of Injury:	01/14/2014
Decision Date:	08/28/2014	UR Denial Date:	05/16/2014
Priority:	Standard	Application Received:	06/16/2014

HOW THE IMR FINAL DETERMINATION WAS MADE

MAXIMUS Federal Services sent the complete case file to an expert reviewer. He/she has no affiliation with the employer, employee, providers or the claims administrator. The expert reviewer is Board Certified in Orthopedic Surgery and is licensed to practice in California. He/she has been in active clinical practice for more than five years and is currently working at least 24 hours a week in active practice. The expert reviewer was selected based on his/her clinical experience, education, background, and expertise in the same or similar specialties that evaluate and/or treat the medical condition and disputed items/services. He/she is familiar with governing laws and regulations, including the strength of evidence hierarchy that applies to Independent Medical Review determinations.

CLINICAL CASE SUMMARY

The expert reviewer developed the following clinical case summary based on a review of the case file, including all medical records:

The claimant is a 50-year-old female who sustained a right shoulder injury on January 14, 2014. The report of the January 30, 2014, MRI showed partial thickness supraspinatus tendon tearing, no evidence of full thickness rotator cuff tearing and moderate acromioclavicular joint arthritis. Degenerative changes at the labrum were noted. The records available for review note that conservative treatment has included medication management, activity modification, therapy and a corticosteroid injection. On the April 18, 2014, clinical assessment, the claimant reported continued complaints of shoulder pain that worsen with activities. Physical examination findings include tenderness at the acromioclavicular joint, limited elevation and positive Neer and Hawkins testing. Positive pain with cross body testing was also reported. This request is for: right shoulder arthroscopy, rotator cuff and labral assessment, subacromial decompression and distal clavicle excision; and the 14-day, post-operative use of a cold therapy unit.

IMR ISSUES, DECISIONS AND RATIONALES

The Final Determination was based on decisions for the disputed items/services set forth below:

Right shoulder scope rotator cuff and labral repairs, subacromial decompression, distal clavicle excision: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints Page(s): 209-211. Decision based on Non-MTUS Citation ODG(The Official Disability Guidelines) Shoulder Chapter SLAP lesions. Article "Direct Arthroscopic Distal

Clavicle Resection" (Iowa Orthop J. 2005; 25: 149-156)
(<http://www.pubmedcentral.nih.gov/articlerender.fcgi?artid=>

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints Page(s): 210-211. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Treatment in Worker's Comp, 18th Edition, 2013 Updates: shoulder procedure - Surgery for SLAP lesions; Partial claviclectomy (Mumford procedure).

Decision rationale: Based on California MTUS ACOEM Guidelines and supported by Official Disability Guidelines, the request for right shoulder scope for rotator cuff and labral repairs, subacromial decompression, and distal clavicle excision would not be indicated. ACOEM Guidelines support surgical intervention following six months of conservative care, including injection therapy. At the time of the recommendation for surgery, the claimant was less than three months post-injury. In addition, the MRI scan demonstrated partial thickness rotator cuff tearing but no indication of acute labral or full thickness rotator cuff pathology. Due to a clinical presentation that would not indicate surgery and a lack of six months of conservative care, this request for Right Shoulder Scope Rotator Cuff and Labral Repairs, Subacromial Decompression, Distal Clavicle Excision is not medically necessary.

Cold therapy unit shoulder x 14 days-purchase: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation ODG(The Official Disability Guidelines) Cryotherapy.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints Page(s): 201-205, 555-556. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Treatment in Worker's Comp, 18th Edition, 2013 Updates: shoulder procedure - Continuous-flow cryotherapy.

Decision rationale: The requested right shoulder scope for rotator cuff and labral repairs, subacromial decompression, and distal clavicle excision is not established as medically necessary. Therefore, the request for the 14-day, post-operative use of a cold therapy unit is not medically necessary.